STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000447	A. BUILDING _____ B. WING _____	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS HEALTH CARE CENTER	604 RENNAKER ST LA FONTAINE, IN 46940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS This visit was for an initial survey of the Nurse Aide Training Program. Date: 04/20/2010 Facility Number: 000447 Provider Number: 155551 Surveyor: Gina Berkshire, RN The Rolling Meadows Health and Rehab was found to be in compliance with the Administrative Standards for the Indiana State Department of Health Nurse Aide Training Program, 410 IAC 16.2-3.1-14 and CFR 483, subpart B.	T 000		